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Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Re: File Code CMS-2279-P

Thank you for the opportunity to review and comment on the proposed rules prohibiting the use of federal Medicaid funds to support graduate medical education (GME) as published in the Federal Register on May 23, 2007 (72 Fed. Reg. 28930). The State of Arizona strongly supports CMS continuing to allow states to utilize Medicaid funds to support GME programs' direct and indirect costs. State Medicaid programs cannot assure adequate health care access without strategic policy tools like GME.

As Director of the Arizona Health Care Cost Containment System (AHCCCS), Arizona's single State Medicaid Agency, I submit the following comments pertaining to those rules.

Summary of policy rationale to oppose the proposed rule changes.

1. **Consistency with Medicare**. CMS has historically allowed states to financially support GME programs through both direct and indirect cost reimbursement methodologies. This is a beneficial strategy to reduce manpower shortages and is consistent with authority under Medicare.
2. **Discretion to the states**. Medicaid is a federal/state partnership that allows states discretion in establishing service and program reimbursement methodologies consistent with program goals and that assures maintenance of effort within budget neutrality targets. GME falls within this discretionary authority.
3. **Meeting Federal requirements**. Federal requirements for state Medicaid programs include access to care and cost effectiveness. GME programs enhance service capacity and cost savings through physician residents at teaching hospitals and ambulatory care clinics assuring the state's supply chain of future providers.
4. **Provider shortages increase costs**. The Medicaid program has grown, increasing the demand for primary and specialty medical care. It is antithetical to reduce financial support to a program like GME, which is critical to meet this growing demand. Moreover, it is well documented that provider shortages in public programs leads to higher emergency room and inpatient utilization by Medicaid beneficiaries.

Medicaid GME funding has been recognized implicitly since the program's inception.

I disagree with the assertion that it is inconsistent with the Medicaid statute to pay for direct costs associated with GME. Arizona's utilization of Medicaid funds as a source of program revenue to finance GME is well-grounded. While there is, in fact, no statutory requirement for states to make GME payments, the Centers for Medicare and Medicaid Services (CMS) has recognized its implicit authority to make federal financial participation available for direct GME costs both in its rulemaking, as expressed in the current 42 C.F.R. §§ 438.6 and 438.60, and in its approval of Arizona's state plan amendments in 1993, 1998, and 2000.

Acting on approval by CMS, other states have made GME payments under their Medicaid programs since the beginning of the program. Medicaid payments for GME have been recognized and reviewed by the Office of Inspector General and the General Accountability Office. And despite this long history, Congress has never intervened to end CMS' authority to approve the use of Medicaid funds for GME program support.

Medicare's underlying policy rationale for GME is applicable to Medicaid today.

In addition, while the Medicaid statute does not explicitly authorize the expenditure of federal funds, the rationale for providing the express authority in Medicare also applies to Medicaid. In providing the explicit authority in Medicare, Congress was responding to general concerns that the nation was suffering from a shortage of physicians. Congress believed that educational activities contributed to the quality of care within institutions, and such activities were necessary to meet community needs for trained personnel. While it is true that Congress decided Medicare should only participate until communities shouldered the costs in some other fashion, Congress has not acted to substantially limit or eliminate Medicare subsidies for GME.

Arizona, as the nation's fastest growing state, is facing an imminent physician workforce crisis. Recently, researchers at the Arizona State University and the University of Arizona published the *Arizona Physician Workforce Study, Part I*, which found that Arizona had 20.7 physicians per 10,000 people – substantially below the national average of 28.3. The study also found a disturbing misdistribution of physicians, ranging from a high of 27.6 in urban Pima County to a low of 4.8 in rural Apache County.

Arizona is taking action to address this workforce crisis. With the recent opening of the joint University of Arizona-Arizona State University medical school in Phoenix, Arizona now has two allopathic and two osteopathic schools of medicine. Researchers have demonstrated that there are clear connections between locations of medical schools and residency training, and between residency training and initial practice locations. Simply put, states with a higher percentage of physician residents from in-state medical schools are more likely to retain in-state graduates for residency; likewise, states with a higher percentage of physician residents from in-state medical schools are more likely to retain physicians of all specialties in all geographic locations. Therefore, Arizona's expansion of in-state medical school capacity can expand Arizona's physician workforce, *but only if* Arizona has sufficient capacity of in-state graduate medical education programs to accept more in-state graduates. Medicaid GME funds are a critical tool

for maintaining and expanding physician capacity. Medicaid, as a payer for 18% of all Arizonans, is a vital component of the healthcare fabric of this state.

GME programs add directly to the state's service capacity by providing clinical services to Medicaid beneficiaries. Additionally, GME programs train the next generation of providers, which assures not only future capacity but also providers who are up-to-date with the changes in evidence-based medicine and the access and quality of care requirements of public programs that have been part of their training program.

Address accountability concerns through regulation and guidance.

Reviewing the notice and proposed rule, it appears that CMS has significant concerns regarding accountability in the use of Medicaid GME funds. The notice asserts that traditional Medicaid financing of GME

> assures Federal participation, but does not provide clear accountability. Funding intended by the States to support GME often becomes subsumed within MCO or hospital rates (including supplements to these rates) or inpatient disproportionate share hospital (DSH) payments. As a result, it is difficult to quantify Medicaid GME payments or monitor and measures the effect of Medicaid payments on GME programs.

72 Fed. Reg. 28930, 28932 (May 23, 2007). Although there are some challenges of accountability regarding the use of federal matching funds for GME, the solution is not to scrap the program altogether, removing billions of dollars from the nation's teaching hospitals and medical education training programs. Rather, steps should be taken at the federal level to link Medicaid GME financing to the achievement of specific workforce objectives while continuing to provide states with flexibility to demonstrate innovative ways to meet those objectives.

As an example, by linking GME funding to the achievement of the state's workforce objectives, and to serving Medicaid-eligible persons, Arizona is holding teaching programs – and itself – more accountable for the use of GME funds. Traditionally, Arizona has modeled Medicaid GME payments after Medicare's payments, providing no restriction on specialties of physicians being trained and providing little assistance to cover the costs of training physicians in rural and non-hospital settings. Recently, however, Arizona has altered its Medicaid GME program to link payments directly to its workforce objectives.

In 2006, Arizona Governor Janet Napolitano secured an additional $12 million for the expansion of existing residency programs and for the development of new residency programs. This year, Governor Napolitano requested an additional $9 million in total funding for GME. The Governor's proposal explicitly links the new funding to the achievement of the state's physician workforce objectives by directing funds toward new teaching programs in rural counties, new residency positions that include rural county rotations, and to programs that encourage residents to establish permanent practices in rural counties. Programs receiving GME funding in either

year, must identify and report the number of new residency positions created, including positions in rural areas.

Arizona goes beyond merely recognizing that financing physician training benefits all members of a community. In Arizona, explicit funding for GME is linked to the provision of services to Arizona's Medicaid members. AHCCCS has established a Memorandum of Understanding (MOU), voluntarily entered into between AHCCCS, a teaching program, and a Medicaid managed care organization. Upon entering into the MOU, AHCCCS and the Medicaid MCO work together to ensure that a sufficient number of Medicaid members are assigned to the teaching program to support that teaching program. Teaching programs in Arizona have as many as 7,000 assigned Medicaid members. In this way, GME funding directly benefits the many AHCCCS members who receive care at the teaching program. In turn, teaching programs provide educational opportunities for residents to familiarize themselves with principles of managed care and encourage residents to locate practices in Arizona.

With millions of dollars at stake, Arizona has a substantial interest in Medicaid GME funding. The abrupt and arbitrary elimination of this funding jeopardizes Arizona's efforts to address its workforce crisis, and the loss of funds will impact access to care, quality of care and preventive medicine at the very time that the President and Secretary are urging transparency and value driven health care decisions.

As a public servant, I share CMS' concerns regarding the accountability of public funds and take very seriously our fiduciary responsibility to taxpayers. It appears that due to these concerns, CMS wants to terminate GME funds putting at risk the ability of our state to build the physician workforce needed for the future. For these reasons, I respectfully request CMS to rethink this decision and work with its state partners to create the appropriate level of accountability necessary to maintain this vital program.

Sincerely,

Anthony D. Rodgers
Director